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CAVEATS ON VALUES GUIDING COMMUNITY RESEARCH AND ACTION

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Steve Fawcett's (1991) article is the work of a most dedicated researcher who has managed over many years to blend the best attributes of behavior analysis with community and political concerns. During these many years, Steve has not wavered in his commitment to conceptual and technical excellence in the service of helping marginal people in our society gain more control over their daily lives.

It is impossible for me to find any fault with the dedication of Steve's career and the general thrust of this paper. The paper itself serves as a personal credo and career statement. Steve's overriding interest in developing collaborative, participatory research projects with citizens, his call for focusing more research on those individuals who wield power (as opposed to the victims of power), and to end our entrenchment in "pure" methodological rigor at the expense of research relevance are the major points of this paper. These overriding issues are also nonarguable, from my perspective.

I do, though, have some specific points of question and concern—caveats—lest the current paper in its entirety be taken as the "community research manifesto." Although this is not Steve's purpose, a danger is that this paper can become dogma rather than a point of departure for more analysis, research, and action. Here are some points and questions for such analyses, research, discussion, and subsequent action.

Who Decides?

I continue to have questions about how well communities decide priorities for preventive interventions. How, in fact, are priorities decided? What is the process? How is a consensus reached when the researchers and community representatives disagree?

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For example, the personal and community destruction from drug abuse (e.g., crack cocaine) is unquestionable. Events surrounding drug abuse are also often dramatic and newsworthy. Many communities will list ending drug abuse as a first priority. Yet if we examine the drugs in our society that result in the greatest loss of life, health care costs, and loss of productivity, they are alcohol and nicotine (U.S. Department of Health and Human Services, 1991). These are drugs that are legally sold to adults and abused by millions of people. Effective interventions involve increasing costs to consumers (Warner & Murt, 1984) and decreasing availability (Altman, Rasenick-Douss, Foster, & Tye, 1991). Should researchers steer community representatives toward intervention with our nation's drugs of choice? Do they forcefully suggest structural interventions (increased taxes, enforcement of laws) as the change strategies? What happens after attempts by the researchers at influencing the community fail and community groups still want to invest time and energy in small-group interventions (e.g., treatment groups for crack addicts) that may have little, if any, probability of success? Although we acknowledge that we "experts" don't have all the answers, some of us believe that community representatives are not always inherently wise and will follow the most socially valid path. Do we then leave the community or follow what may be a less socially valid path?

This issue was discussed at greater length in this journal's special issue on social validity (Vol. 24, No. 2). Some of this discussion involved merging "top-down" and grassroots approaches to community change. Other points related to the very large population-attributable health risk that is a function of such mundane behaviors as those involved in dietary and exercise practices. Intervention in these practices is most often not dramatic, nor viewed as a high priority. Yet on a population basis,

alteration of dietary and exercise patterns is likely to yield very high benefits.

Prevention of What for Whom?

A second question concerns prevention. As sacred as the term is to many of us, we must finally accept that not every problem is preventable. In addition, at least on a technological and cost basis, there may be some problems for which our best strategy is late secondary prevention (identification and treatment of a recognizable disorder) rather than primary prevention (Russell, 1986). In secondary prevention, our resources are very targeted; those who are identified with a problem (e.g., hypertension) receive a tailored treatment (dietary counseling, medication). Primary prevention is population-based. Everyone receives an intervention even though many persons are not at risk. For some problems and interventions, we have to scrutinize more carefully the facts before blindly proclaiming for primary prevention (e.g., see Brownes, Westenhouse, & Tice, 1991, for estimates of population benefits of dietary change, although their figures underestimate the effects of more fat-restricted diets; Southard et al., in press).

A related point is that not everyone is realistically a good target for preventive interventions. Research with stages-of-change models indicates that only a small percentage of people (10% to 20%) are at a point at which they are ready to change key health behaviors (e.g., change their diets, cut down on cigarettes). Do we invest our finite resources on the small percentage of people who are ready to change (where we will likely be successful) or on convincing the much larger number of people that it is to their advantage to change certain behaviors? Although stages-of-change models (Prochaska & DiClemente, 1983) have mostly addressed change at the individual level, it is probable that the same conceptualization pertains to individuals distal to a problem (e.g., corporate heads who can decide advertising policies for alcohol and cigarettes) and, perhaps, also to entire communities. Indeed, very few individuals and communities may be ready for change. We may better use our minimal resources with those individuals and communities ready for change.

Another question is more emotionally charged. Merely raising the question risks labels of "social Darwinism" and "political *in*correctness." The question is, "As a society, are we better off investing our preventive efforts in the 'haves' or the 'have-nots'?" On the one hand, the obvious peril is the rich get richer. On the other hand, we may be sadly disturbed to find after years of preventive interventions with the poor that poorer persons' major problem remains at once very simple and very complicated: their lack of money. Should our efforts shift toward economic development in the entire country (i.e., the "trickle-down" approach) and better access to basic medical care (which is treatment, not prevention)? Should we focus on the "working poor" who most often receive no federal, state, or employer-based health care plan? Or, if we are more interested in curbing health care expenditures, should we more directly focus on the small percentage (about 10%) of the population with chronic illnesses and disabilities? Care of persons with chronic diseases and disabilities may use as much as two thirds of our nation's health care expenditures (Wicker, 1991).

I don't claim to know the answers to these perplexing questions, but I will offer some opinions. I lean toward economic development and access to basic medical care as our top priority for poor people. Also, if we are ever to reduce health care expenditures, we must develop less expensive ways of treating chronic diseases (including simply less treatment of some disorders).

I also do not feel it is a mistake to focus considerable (though certainly not all) prevention resources on the "haves" in our society, especially when the "haves" also include individuals from lower and middle sociodemographic levels. After all, although it is true that poor people bear the burden of many health problems, it is also true that most people in our country are not poor but still do suffer some predictable health problems (USDHHS, 1991). Community health promotion that involves individual health behavior change *may*

be better directed to those persons who do not have to struggle constantly with issues of daily survival. It is not demeaning to conclude that structural changes appear to be necessary to prevent the health problems of the poor.

Local Resources?

A final point pertains to developing innovations that solve problems and are sustainable with local resources. Although a retreat from federalism has been popular for well over a decade on both sides of the political spectrum, it must be said that not every problem is solvable at the local level. For example, our national trade policies have drastic effects on the viability of certain industries. An industry's demise is often a local catastrophe caused by national policies. The fix may not exist in the local community.

Alcohol may remain overwhelmingly enticing to adolescents despite the best grassroots and adolescent school-based alcohol prevention program. Changing the depiction of alcohol on television requires national initiatives to influence the guidelines and power of national agencies (e.g., the Federal Communications Commission).

Federal and corporate funds often have to support local efforts. Communities typically are unable, because of a minimal tax base, to sustain innovative educational programs that can teach poorer high school students marketable skills. If, for example, a basic goal is computer literacy upon high school graduation, the federal government and corporations may have to subsidize local school districts' support of teachers and purchase of equipment.

Thus I question why innovations must fit the guideline of "locally sustainable." In many ways, this guideline absolves federal and state governments and corporate entities of responsibilities to communities. Surely none of us sees such a guideline as desirable.

In summary, I greatly admire Steve Fawcett's work and his most recent statement on values and research in the community. The article provides guidelines and directions. Perhaps even more important in the long run, the article is provocative and makes us ponder and debate some of the most difficult issues of our time.

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